MEDI-CAL UPDATE

Outpatient Services
Bulletin 347

Billing and Policy
Rehabilitation Clinics Bulletin 347 — September 2003

Contents

Articles with related Part 1 Manual Replacement Pages may be found in the "Program and Eligibility" bulletin. Articles with related Part 2 Manual Replacement Pages may be found in the "Billing and Policy" bulletin. The Medi-Cal Update *may not always contain a "Billing and Policy" section.*

HIPAA: Provider Manual Updates

The September 2003 Health Insurance Portability and Accountability Act (HIPAA) implementation resulted in the following changes in the Medi-Cal provider manuals. All changes are effective for dates of service on or after September 22, 2003.

Important: When you follow the remove and replace instructions in this bulletin and update your manual, please retain the pages you remove. Place them after the *Appendix* tab at the back of your manual. These page will help you bill for services that you rendered prior to September 22, 2003.

New HIPAA In Review

A handy *HIPAA In Review* guide has been included in this bulletin for you to insert in your provider manual at the end of the *UB-92 Completion: Outpatient Services* section. This guide summarizes important outpatient-related changes that resulted from the September 2003 initial phase of Medi-Cal HIPAA implementation.

Conversion of Place of Service to Facility Type Codes

Type of Bill Field (Box 4) and
Payer Field (Box 50)

4. TYPE OF BILL
734

Local Medi-Cal Place of Service codes are being replaced with national facility type codes, which are entered as the first two digits in the Type of Bill field (Box 4) in the upper right hand corner of the claim. Previously, Box 4 was optional but now is required. The third character in the Type of Bill field is a claim frequency code (a single number or letter).

50. Payer
O/P Medi-Cal ~~9~~

Local Medi-Cal Place of Service codes are no longer included in the Payer field (Box 50). The words "O/P Medi-Cal" are still required.

Manual Changes

- Facility type and claim frequency codes are explained in the *National Uniform Billing Committee (NUBC) UB-92 Billing Manual.* This information is included in the claim completion section.
- Medi-Cal manual references to Place of Service are changed to "facility type."

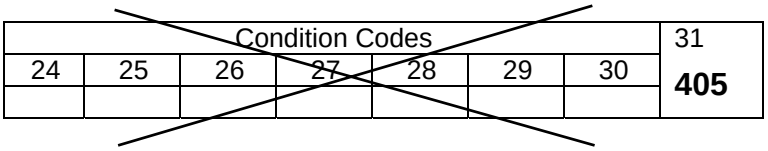
Please see **HIPAA**, *page 2*

HIPAA *(continued)*

- A *Code Correlation Guide* showing the relationship between Place of Service and facility type codes is added at the end of the *UB-92 Completion: Outpatient Services* section to help you understand how the Medi-Cal Place of Service codes have been converted to national facility type codes.

Conversion of Billing Limit Exception to Delay Reason Codes

Delay Reason Field (Box 31)

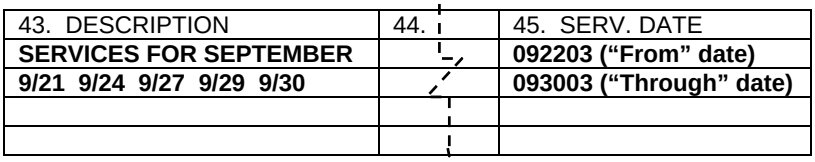


Local Medi-Cal billing limit exception codes are being replaced with national delay reason codes. Delay reason codes are entered in Box 31, to the right of the Condition Codes boxes on the claim. Do not enter delay reason codes in the Condition Codes field (Boxes 24 – 30) where you previously entered billing limit exception codes.

- A *Code Correlation Guide* showing the relationship between billing limit exception and delay reason codes is added at the end of the *UB-92 Completion: Outpatient Services* section to help you understand how Medi-Cal billing limit exception codes have been converted to national delay reason codes.

"From-Through" Billing

Service Date Field (Box 45)



"From-through" services with a "from" date of service on or after September 22, 2003 are to be billed with national codes. "From-through" services with a "from" date prior to September 22, 2003 are billed with local Medi-Cal codes.

Guidelines

HIPAA changes for the September 2003 phase of HIPAA implementation established the following guidelines:

- Claims with dates of service on or after September 22, 2003 must be submitted with national condition, delay reason and patient status codes.
- Claims for services prior to September 22, 2003 must be billed with local Medi-Cal condition, billing limit exception and patient status codes.
- Claims for services rendered on dates of service that include both pre- and post-September 22, 2003 dates must be billed on separate claims (split billed) with national codes on one claim and local Medi-Cal codes on another.

"From-Through" Exemption

Claims for services that require "from-through" billing (identified in policy sections) do not require the split billing. They are billed as indicated in the italicized text under the preceding diagram.

Please see **HIPAA**, *page 3*

HIPAA *(continued)*

Manual Changes

- The *UB-92 Special Billing Instructions for Outpatient Services* section is updated to include the preceding "from-through" information.

Conversion of Condition Codes

Condition Codes Field (Boxes 24 – 30)

Medi-Cal condition code A3 is being changed to national condition code "AI," which is used to bill for services related to Family Planning (FP).

Emergency Services

Admit Type Field (Box 19)

ADMISSION			
17. DATE	18. HR	19. TYPE	20. SRCE
NA	**NA**	**1**	**NA**

Enter admit type code 1 when billing for outpatient emergency services. This is now a required field when billing for emergency services.

Manual Changes

- The *UB-92 Completion: Outpatient Services* section is updated to include instructions to complete the *Admit Type* field (Box 19) when emergency services are rendered.

Modifiers

HCPCS/Rates Field (Box 44)

44. HCPCS/RATES	45.	46.	47.	48.	49.
XXXXX2647					**6062**

Up to four modifiers may be entered on outpatient UB-92 claims. Modifiers one and two (-26 and -47 in the preceding example) must be billed immediately following the procedure code, with no spaces, in the HCPCS/Rates field (Box 44). The remaining two modifiers (-60 and -62 in the preceding example) are entered, with no spaces, in Box 49.

Manual Changes

- The *UB-92 Completion: Outpatient Services* section is updated to include instructions for billing with up to four modifiers.
- When billing for services rendered to recipients who are patients in subacute care facilities, you must enter facility type code "27" in the *Type of Bill* field (Box 4) and enter modifier -HA (pediatric) or -HB (adult) in the last-used modifier field. These modifiers must be submitted with every procedure on the claim.

2003 CPT-4 and HCPCS Updates: Implementation September 22, 2003

The 2003 updates to the *Current Procedural Terminology – 4th Edition* (CPT-4) and Healthcare Common Procedure Coding System (HCPCS) National Level II and local Level III codes are effective for Medi-Cal for dates of service on or after September 22, 2003. Some of the policy changes are highlighted below.

SURGERY

Deleted and Replacement CPT-4 Codes

The following are deleted codes and their 2003 replacement surgery codes. Unless otherwise noted, the policy of the deleted code applies to the replacement code.

Deleted	Replacement
36520	36511 and 36512
36521	36516
38231	38205 and 38206
44209	44238
53670	51701 and 51702
53675	51703
58551	58545 and 58546
86915 (Pathology/Laboratory)	38210 – 38213

The updated information is reflected on manual replacement pages non ph 6 and 10 (Part 2).

Reimbursement Restrictions

The following CPT-4 codes have Medi-Cal reimbursement restrictions:

- 36450 may only be reimbursed for newborns (up to 1 month of age)
- 36455 may only be reimbursed for recipients older than 1 month of age
- 38204 and 38242 will be priced "By Report"
- 43219, 45317, 51705 and 62284 are no longer reimbursable to an assistant surgeon
- 55866, 58290 – 58294 and 58552 – 58554 are once-in-a-lifetime procedures
- 57452 is not reimbursable when billed with codes 57454 – 57461
- 57456 is not reimbursable when billed with code 57461
- 58146 is not reimbursable when billed with codes 58140 – 58145 and/or 58150 – 58240
- 58263 requires a *Treatment Authorization Request* (TAR) for the primary surgeon
- 58290 and 58291 require a *Treatment Authorization Request* (TAR) for both the primary and assistant surgeon
- 61313 is not reimbursable when billed with codes 61322 and/or 61323
- 62263 and 62264 are not reimbursable when billed with codes 76005 and/or 72275
- 62264 is not reimbursable when billed with code 62263

The updated information is reflected on manual replacement page non ph 6 and 10 (Part 2).

Please see **HCPCS**, *page 5*

HCPCS *(continued)*

PATHOLOGY/LABORATORY

Reimbursement Restrictions
The following CPT-4 codes have reimbursement restrictions:

- 89055 is a 100 percent technical procedure and must be billed with modifier -TC
- 85004 and 85032 are reimbursable to podiatrists with prior authorization
- 85048 is no longer reimbursable to podiatrists

The updated information is reflected on manual replacement pages non ph 6 (Part 2).

DURABLE MEDICAL EQUIPMENT

Deleted and Replacement Code
The following is a deleted Durable Medical Equipment (DME) code and the 2003 replacement codes. The policy of the deleted code applies to the replacement codes.

Deleted	Replacement
E0608	E0618 and E0619

The updated information is reflected on manual replacement page medi non hcp 1 (Part 2).

DME Supplies and Accessories Reimbursement Restrictions
The following HCPCS codes have Medi-Cal reimbursement restrictions:

- A7032, A7033, A7038 and S8265 are limited to two each per month
- A4606 is limited to six per month
- A7034 is limited to once in a three-month period
- A7035, A7036 and A7039 are limited to once each in a six-month period
- A7030 and A7031 are limited to once per year
- A7044 is limited to twice per year

Surgical Procedure Codes: Update

Effective for dates of service on or after September 22, 2003, providers may no longer bill with CPT-4 code 53670 (catheterization, urethra; simple). Providers must instead bill with one of the following new CPT-4 codes:

CPT-4 Code	Description
51701	Insertion of non-indwelling bladder catheter (eg, straight catheterization for residual urine)
51702	Insertion of temporary indwelling bladder catheter; simple (eg, Foley)

Codes 51701 and 51702 are considered incidental procedures and are not separately reimbursable when billed with CPT-4 surgery codes 10021 – 69979 for the same recipient, by the same provider, for the same date of service.

The updated information is reflected on manual replacement page non ph 6 (Part 2).

Instructions for Manual Replacement Pages
Rehabilitation Clinics (REH) Bulletin 347 — September 2003

Part 2

Remove and replace:	audio 9/10 * cif co 1/2 * hcpcs iii 1 thru 4 *
Remove: Insert:	inject 1 thru 44 inject 1 thru 43 *
Remove and replace:	inject list 1 thru 19 * inject vacc 1 * medi cr op 3/4, 7/8, 11/12, 23/24, 27/28 * medi cr op ex 3/4, 7/8 * medi non hcp 1/2 modif app 1 thru 4 *
Remove: Insert:	modif used 3 thru 9 modif used 3 thru 10 * *(new)*
Remove: Insert:	non ph 5 thru 15 non ph 5 thru 14
Remove and replace:	non ph ub 1 thru 3 * oth hlth cpt 3 * rehab 3/4 * respir 5/6 * spe dev 5/6 * tar comp 9 thru 12 * ub comp op 1 thru 30 **(new)*
Insert at end of the *UB-92 Completion: Outpatient Services* Section:	*HIPAA In Review (new)* *Code Correlation Guide (new)*
Remove: Insert:	ub spec op 1 thru 8 ub spec op 1 thru 9 **(new)*
Remove and replace:	ub sub 1 thru 5 *
Remove: Insert:	ub tips op 1 thru 3 ub tips op 1 thru 4 **(new)*
Remove and replace:	vaccine 3 thru 7 *

* Pages updated due to ongoing manual updates